U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 23 September 2005Case No.: 2004-BLA-6815

In the Matter of:

Ronald D. Harrison,
Claimant

v.

Sunset Land & Coal Company,
Employer

And

Director, Office of Workers' Compensation Programs,
Party-In-Interest

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by Ronald Harrison [hereinafter "Claimant"], a coal miner, under the Black Lung Benefits Act, 30 U.S.C. § 901, et seq. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations. [1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before me on April 13, 2005 in Abingdon, Virginia, at which time all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations, Parts 410, 718, 725, and 727. At the hearing, I admitted into the record

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on January 17, 2002 (DX 3), the new regulations are applicable.

Director's Exhibits (DX) 1-55,[2] Claimant's Exhibits (CX) 1-3, Employer's Exhibits (EX) 1-13, and ALJ Exhibits (ALJ) 1-3.

I have based my analysis on the entire record, including the hearing transcript (Tr.), exhibits, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

Procedural History

The Claimant filed his claim for black lung benefits on January 17, 2002 (DX 3). On November 25, 2002, the District Director (Director) issued a Proposed Decision and Order awarding benefits (DX 31). The Employer requested a hearing with the Office of Administrative Law Judges on December 23, 2002. (DX 32) The claim was forwarded March 24, 2003 (DX 36), and a hearing was held on October 21, 2003 before Administrative Law Judge Mollie W. Neal. At the hearing, the Claimant attempted to submit evidence outside the time frame allowed for the submission of new evidence, and the claim was remanded to the Director to consider that evidence. (DX 44)

The Director issued a second Proposed Decision and Order awarding benefits on July 13, 2004, again finding that the Claimant had established that he had pneumoconiosis that arose from his coal mine employment, and that he was totally disabled due to pneumoconiosis. (DX 50) The Employer timely filed a request for a hearing with the Office of Administrative Law Judges. (DX 51) The Director forwarded the claim and on April 13, 2005 in Abingdon, Virginia, I held a hearing.

The Claimant filed a previous claim on April 10, 1997 (DX 1). On July 15, 1997, the Director denied the claim, finding that the Claimant had not established that he was totally disabled by pneumoconiosis. The Claimant did not further pursue this claim, and it was administratively closed.

Issues

The issues contested by the Director and the Employer are:

1. The timeliness of the Claimant's claim;
2. The length of the Claimant's coal mine employment;
3. Whether the Claimant has pneumoconiosis;
4. If so, whether the Claimant's pneumoconiosis arose out of coal mine employment;
5. Whether the Claimant is totally disabled;
6. If so, whether the Claimant's disability is due to pneumoconiosis;

[2] Dr. Foster's office note and CT and x-ray interpretation of March 31, 2003 (DX 43) were not admitted into evidence at the hearing, pending a review of these films by the Employer. (Tr. at 9) After the hearing, the Employer submitted a rebuttal interpretation of these films by Dr. Wheeler. Accordingly, I have considered Dr. Foster's office notes and interpretations, as well as Dr. Wheeler's.

7. The number of dependents for purposes of augmentation of benefits;
8. Whether the named Employer is properly designated as the responsible operator.

(DX 52; Tr. 22-24).

FINDINGS OF FACT AND LAW

Background

Mr. Harrison, who testified at the hearing, resides in Rogersville, Tennessee. (Tr. at 25) He has two dependents: his wife Diane, whom he married on June 3, 1972, and his 12 year-old adopted son, Christopher. (Tr. at 25-26) The Claimant has 12 years of education, and graduated from high school. (Tr. at 39) Mr. Harrison's last coal mine employment was at Sunset Coal in Virginia in August of 1992, where he worked for four or five years. (Tr. at 27, 36, 42) Other than 13 months in the Air Force as a hospital medic and approximately 7 months working for General Motors, he has worked only in the mines since he was 16. (Tr. at 28, 36, 38) The Claimant left work because Dr. Patel told him that if he did not quit the mines, his lungs and heart would deteriorate. (Tr. at 37)

Claimant's job at the mines consisted of working in the face area, where the miners cut the coal and send it outside. (Tr. at 28-29) Claimant primarily ran the machines used to cut the coal. (Tr. at 29) He sat on a machine about 20 feet back from where the coal was being cut. (Tr. at 33) He sometimes would have to cut through rock, which produced white rock dust, in order to get to the coal. (Tr. at 34-35)

Mr. Harrison also drilled holes and set off dynamite. (Tr. at 29-30) During the Claimant's earlier years as a miner there was no ventilation, and the smoke took a long time to clear after the explosions. (Tr. at 31) His other duties included running roof bolters, "shooting with powder," shoveling coal, and working as a rock duster, which involved throwing dust with his hands or using a dusting machine to spray the dust. (Tr. at 29, 32-33) Although Mr. Harrison was supposed to wear a mask when working in the mines, he could not breathe with the mask on, so he did not always wear it. (Tr. at 35)

Claimant admitted that he used to smoke occasionally, but he quit approximately one month earlier. (Tr. at 37, 43) He smoked a couple of cigarettes a day, but never while he was working in the mines. (Tr. at 37, 43) This habit lasted for 25 or 30 years. (Tr. at 43)

Claimant does not feel he is able to go back into the mines at this time. (Tr. at 40) His current condition is fair, and he feels weak; shortly before this hearing, he had stents put in the arteries in his heart. (Tr. at 26-27)

The Director determined that the Claimant worked as a coal miner for approximately 22 and a quarter years, from 1967 to 1992. This is supported by the

Claimant's Social Security Earnings record (DX 6). These records also reflect that the Claimant worked for Sunset Land & Coal Co. Inc. from 1989 to 1992, and that Sunset was his last coal mine employer. Accordingly, I find that the Claimant has at least 22 years of coal mine employment, and that the named Employer is properly designated as the responsible operator. I also find that the Claimant has two dependents for purposes of augmentation of benefits, namely his wife Diane, and his son Christopher.

The Employer contests the timeliness of the Claimant's claim. The Claimant's original claim was filed on April 10, 1997. 20 C.F.R. § 725.308 provides that

> A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later.

The regulations also provide that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). The Board has held that a determination of total disability due to pneumoconiosis must be "actually received" by the miner, and if so, there must be a finding that the miner was capable of understanding the report. *Adkins v. Donaldson Mine Co.,* 19 B.R.R 1-34 (1993).

There is nothing in the exhibit record to indicate that the Claimant was diagnosed with a total disability due to pneumoconiosis at any time before he filed his application on April 10, 1997. Given the presumption that a claim is timely filed, and the total lack of any evidence to rebut this presumption, I find that the Claimant's claim for benefits was timely filed.

Discussion

To prevail in a claim for Black Lung benefits, a claimant must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in 20 C.F.R. § 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202-718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants when the parties' evidence was in equipoise. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

The instant claim is a "duplicative" or "subsequent" claim because a prior claim was finally denied over one year ago. There is, accordingly, a threshold issue as to whether there are grounds for reopening the claim under 20 C.F.R. §725.309. A subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable

condition of entitlement") has changed and is now present.[3] 20 C.F.R. §§725.309(d)(2), (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. §725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement. In making that determination, I must also consider whether the newly submitted evidence differs "qualitatively" from the evidence submitted during the previously adjudicated claim. *Sharondale Corp. v. Ross*, 42 F.3d 993, 999, 19 BLR 2-10 (6th Cir. 1994).

In the present case, the Claimant's previous claim was finally denied for failure to establish total disability due to pneumoconiosis. Thus, for purposes of adjudicating the present "subsequent" claim, I must first evaluate whether the Claimant is totally disabled due to pneumoconiosis.

Evidence of Totally Disabling Pulmonary Impairment

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment. 20 C.F.R. §718.204(b)(2). For a living miner's claim, total disability may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5). Furthermore, under 20 C.F.R. §718.304, if a claimant can establish the existence of "complicated pneumoconiosis," an irrebuttable presumption arises that the claimant is totally disabled due to pneumoconiosis.

The record includes the following newly submitted evidence relevant to the issue of whether the Claimant is totally disabled.

X-rays

[3] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in this section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) (*Conditions of entitlement: miner*).

Exhibit No. [4]	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*[5]	*Impression*
DX 11	3/14/02	4/15/02	Goldstein / B	Read for quality purposes only[6]
DX 11 (D)	3/14/02	3/14/02	Baker / B	r, r, 1/1, category A opacities
EX 5 (E-R)	3/14/02	6/12/02	Scott / B, BCR	High contrast film quality; no abnormalities consistent with pneumoconiosis; peripheral nodular infiltrates apices compatible with TB; 2 cm mass right apex; granulomatous versus cancer.
EX 9 (E-R)	7/23/02	3/15/05	Scatarige / B, BCR	Underexposed film; negative for pneumoconiosis; subtle nodular infiltrates, both apices close to pleura – favor TB or histoplasmosis. Some calcium in right and left upper lung zones.
CX 2 (C) (DX 47)	7/23/02	8/20/02	Cappiello / B, BCR	r, q, 2/1, category A opacities, complicated pneumoconiosis with coalescent opacities and chronic obstructive pulmonary disease
EX 2 (E)	9/4/02	9/19/02	Wheeler / B, BCR	Underexposed film quality; abnormalities consistent with pneumoconiosis; q, q, 0/1, category 0 opacities, 2-3 cm mass right apex compatible with granuloma, scar or tumor; small nodular infiltrates mixed with tiny calcified granulomata in apices partly healed; few small nodules could be pneumoconiosis.
CX 3 (C) (DX 43)	9/17/02	9/17/02	Verzosa	COPD with diffuse nodularities at both lung fields with conglomerate nodules at the upper lobes, suggestive of coal workers pneumoconiosis. No significant involvement of lower lobes. Upper lobe changes consist of bilateral pulmonary nodules with a conglomerate larger mass at the right upper lobe.
EX 8 (E)	9/17/02	9/30/03	Fino / B	Negative for pneumoconiosis
DX 43 (C)	3/31/03	4/1/03	Verzosa	Lungs have rather diffuse fine nodularities with larger probably conglomerate nodules at the upper lobes as on previous study, most compatible with coal workers' pneumoconiosis. Less changes at lower lungs. No significant calcified lesions or segmental infiltrates.

[4] These x-rays have been designated as "D" for the Director's evidence, "C" for the Claimant's affirmative evidence, "E" for the Employer's affirmative evidence, and "E-R" for the Employer's rebuttal evidence.

[5] "B Reader" and "Board-certified radiologist" are designations that indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[6] Dr. Goldstein noted that the x-ray was positive for coal workers' pneumoconiosis or silicosis, but I have not considered this interpretation, as Dr. Goldstein's function was to review the film for quality purposes only.

Exhibit No. [4]	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*[5]	*Impression*
EX 13 (E-R)	3/31/03	6/13/05	Scatarige / B, BCR	Film overexposed; r, r, 1/0, category 0 opacities; no pleural abnormalities consistent with pneumoconiosis, 2.5 cm focal infiltrate or mass, both lung apices with background of small nodules, favors TB of uncertain etiology rather than pneumoconiosis.
CX 1 (C)	6/5/04	6/29/04	DePonte / B, BCR	r, r, 1/1, category A opacities in mid to upper lung zones, parenchymal abnormalities consistent with pneumoconiosis.
EX 13 (E-R)	6/5/04	6/14/05	Wheeler / B, BCR	q, t, 0/1, category O opacities, negative for pneumoconiosis; 3 cm mass in lower posterior right apex compatible with conglomerate TB more likely than histoplasmosis or cancer, small nodular infiltrates in apices and periphery upper lobes involving pleural compatible with TB or histoplasmosis. Few small nodules could be pneumoconiosis. Mass in right apex is not a large opacity.

CT Scans

DX 43	9/17/02	9/17/02	Verzosa	Multiple nodularities at upper lobe with conglomerate masses at right upper lobe, unchanged from previous study. No development of cavitary lesion; no other pulmonary changes or mediastinal abnormalities. Changes are compatible with coal workers' pneumoconiosis
EX 11, depo ex	9/17/02	4/8/05	Wheeler / B, BCR	Mass, right apex compatible with conglomerate TB. Small nodules in apices and lateral periphery left greater than right, some involving pleura, compatible with TB. Scars compatible with healed pneumonia. Density readings of 58, 74, 102 are indeterminate and 141 is calcified indicating granulomatous disease. Although some small nodules could be CWP, TB is much more likely to give asymmetrical upper lung nodular infiltrate involving apices and pleura. Mass in right apex is not large opacity of CWP because it is apical and not central, and background profusion of small nodules is quite low; also pattern in right apex has evolved to a mass from nodular infiltrate over the last few years favoring a healing granulomatous process
DX 43	3/31/03	4/1/03	Verzosa	COPD with some increased bronchovascular markings and diffuse fine nodularities with larger nodules at the upper lobe, compatible with coal worker's pneumoconiosis. Bilateral pulmonary nodules with conglomerate larger nodules at the right upper lobe, most compatible with coal workers pneumoconiosis.

EX 13	3/31/03	6/16/05	Scott / B, BCR	2.5 cm mass in right apex, probably granulomatous and due to TB. Cannot rule out cancer. Follow-up or biopsy required.

Pulmonary Function Studies[7]

Exhibit No.	***Date***	***Age/Ht***	***FEV1***	***FVC***	***MVV***	***Qualifying***
DX 43	3/1/02	52 / 67"	2.95	4.25	69.5	No
DX 11	3/14/02	52 / 66 ¾"	2.78	4.22	-	No
EX 1	9/4/02	53 / 66"	2.63 2.80	3.99 4.02	75	No

* Results after administration of bronchodilator

Arterial Blood Gas Studies

Exhibit No.	***Date***	***Physician***	***pCO2 (rest) pCO2 (exercise)***	***pO2 (rest) pO2 (exercise)***	***Qualifying?***
DX 11	3/14/02	Baker	35	82	No
EX 1	9/4/02	McSharry	37	82	No

Medical Opinion Evidence

Dr. Glen Baker

Dr. Glen Baker, who examined Claimant at the request of the Director, prepared a report after examining the Claimant on March 14, 2002. (DX 11) He noted the Claimant's history of coal mine employment, as well as his medical history and symptoms. Dr. Baker classified the Claimant's x-ray as 1/1; the pulmonary function test and arterial blood gas study produced normal results.

Dr. Baker diagnosed the Claimant with coal workers' pneumoconiosis, based on his abnormal chest x-ray and history of coal dust exposure. He also diagnosed chronic bronchitis and noted the presence of a nodule of questionable etiology in Claimant's right upper lobe, apparent on his chest x-ray. He believed coal dust exposure and cigarette smoking to be the etiology of the abnormalities. Dr. Baker indicated that the severity of the Claimant's ailments was "minimal with chronic bronchitis and Coal Workers'

[7] There is no evidence of cor pulmonale.

Pneumoconiosis 1/1." He concluded that the Claimant's diagnoses of pneumoconiosis and bronchitis fully contributed to his impairment.

Dr. Baker also completed a form dated March 14, 2002, stating that in his opinion, Claimant has an abnormal chest x-ray from coal dust exposure. (DX 11) He stated that Claimant had no impairment, and had the respiratory capacity to perform coal mining work or comparable work in a dust-free environment.

Dr. Baker also wrote a letter to Claimant, telling him that his x-ray revealed a possible abnormality that needed additional medical attention. He instructed Claimant to contact his personal physician for follow up. (DX 11)

Dr. Roger J. McSharry

Dr. Roger J. McSharry, who is board-certified in internal medicine and pulmonary medicine, examined Claimant at the Employer's request on September 4, 2002, and prepared a report dated September 9, 2002. (EX 1) Dr. McSharry reported the Claimant's occupational and medical histories, and administered arterial blood gas test results at rest, which were normal except for an elevated carboxyhemoglobin level. He also administered pulmonary function tests, which revealed minimal reversible obstructive lung disease and mild restrictive disease with normal diffusion. The Claimant's chest x-ray showed rounded opacities in both upper lung zones, which Dr. McSharry believed to be pneumoconiotic nodules with a profusion level of 2/2. He also pointed out a right upper lobe coalescent region, which he did not believe to be a discrete mass. A B-reading (by Dr. Wheeler) revealed a mass of 2 to 3 centimeters in size and equivocal changes of coal workers pneumoconiosis (0/1 q/q).

On examination, Claimant's chest was clear to auscultation, without wheezes, crackles, or rhonchi. Excursions were normal, with no tenderness to palpation or use of accessory muscles. Dr. McSharry's impression was that the Claimant had symptoms of chronic bronchitis, including shortness of breath, wheezing and sputum production. He also noted angina symptoms compatible with significant coronary artery disease, reflux esophagitis, tobacco abuse, and low back pain.

Dr. McSharry also reviewed some of Claimant's medical records, and noted that the x-ray interpretations were negative for pneumoconiosis, although they identified lesions and a 2-3 centimeter mass in the right apex, which the interpreting doctors felt to be inflammatory disease or cancer. On review of these x-rays, Dr. McSharry noted radiographic changes indicating simple pneumoconiosis, but he was unable to identify with certainty a 1 centimeter or greater mass on the chest radiograph. He did not see evidence of a lesion of progressive massive fibrosis. He recommended Claimant have a CT scan, but Claimant was unwilling to have this done. Dr. McSharry stated that if Claimant underwent a CT scan that revealed a mass in the right upper lung zone, he would have to agree that Claimant has complicated coal workers pneumoconiosis if the surrounding nodules are pneumoconiosis, as he believed they were.

Dr. McSharry concluded that the Claimant does not have a significant pulmonary impairment; the abnormality present on the pulmonary function test could indicate mild asthma, but would not significantly limit his activity. He did not believe this abnormality stemmed from coal dust exposure, stating that the reversibility was consistent with asthma.

Dr. Larry J. Foster

The Claimant saw Dr. Foster on September 16, 2002 for chest pains and shortness of breath. (DX 43) His chest pain was in the substernal area, and he had experienced some tenderness in his chest. His breathing was worse when he slept, and with extreme exertion. An abnormal x-ray had also caused Claimant concern, and prompted this visit.

Dr. Foster reported Claimant's medical, family and social histories. He listed Claimant's medications: Azmacort, Nitro-Dur, Nitrostat, Atenolol, Fluoxetine, Cartia, Aspirin, Prevacid, and Zocor. On examination of the Claimant, Dr. Foster found his head and neck to be positive for headaches, dizziness and nasal/sinus congestion. His cardiovascular examination was positive for hypertension and palpitations. Dr. Foster also noted decreased quality of breath sounds with no rales, rhonchi, or wheezes.

Dr. Foster reviewed the Claimant's medical records, noting that a March 2002 x-ray suggested abnormalities. A July 2002 x-ray suggested pneumoconiosis with bilateral upper lobe opacities. An April 15, 2002 x-ray showed increased bronchovascular markings compared to a January 1997 x-ray. Fibronodular densities of the upper lobes were stable since at least 1997. A spiral CT of the chest performed on April 15, 2002 showed upper lobe changes consistent with conglomerate shadows of coal worker's pneumoconiosis.

Dr. Foster concluded that the Claimant's x-ray was abnormal, with bilateral upper lobe opacities consistent with consolidated shadows of coal worker's pneumoconiosis. He believed Claimant had probable chronic obstructive pulmonary disease due to smoking dependence, hypertension, dyslipidemia, chronic anxiety/depression, and gastroesophageal reflux disease.

The Claimant returned to Dr. Foster on October 7, 2002 for a follow up visit for his shortness of breath, cough, wheezing and abnormal x-rays. (DX 43) On examination of the Claimant, Dr. Foster found his chest to be symmetrical with equal expansion. His lungs were clear, with no wheezes, rhonchi, or crackles.

Dr. Foster reviewed Claimant's laboratory data, finding that a September 17, 2002 CT scan of the chest showed upper lung conglomerate shadows consistent with pneumoconiosis. Pulmonary function studies showed normal spirometry, except for reductions in FEF2575 and the diffusing capacity, which was reduced to 57%.

Dr. Foster concluded that the Claimant had pneumoconiosis and suggested that he remain on his Azmacort inhaler. He believed that Claimant's CT scan showed no progressive changes and recommended that he have a repeat CT scan in six months.

Dr. Foster examined Claimant on April 7, 2003. (DX 43) He found the Claimant's lungs to be clear, with no wheezes, rhonchi, or crackles. Dr. Foster noted that the Claimant's March 31, 2003 x-ray revealed persistent nodularities bilaterally, and confluent shadows in both upper lobes without significant change from prior films. A chest CT scan showed bilateral pulmonary nodules and conglomerate shadows in the upper lobes, primarily on the right. He concluded that the changes were compatible with coal workers pneumoconiosis with progressive massive fibrosis, and recommended follow-up CT scans and x-rays. He believed that the Claimant's condition was stable.

Dr. Gregory J. Fino

Dr. Fino, who is board-certified in internal medicine and pulmonary diseases and a NIOSH B-reader, reviewed Claimant's medical records and prepared a report, dated October 1, 2003, at Employer's request. (EX 8) He also testified by deposition on June 21, 2005. (EX 12) He believed the objective tests of lung function showed that there was no significant respiratory impairment, and no ventilatory abnormality, citing to the Claimant's normal FVC, FEV1, and arterial blood gas test results. He felt that the mild obstructive abnormality shown on Claimant's pulmonary function test was due to his ongoing smoking habit.

Dr. Fino agreed that the Claimant's chest x-rays and CT scans were abnormal. But in his opinion, the Claimant does not have pneumoconiosis, simple or complicated. Relying on the series of x-ray films from 1998 to 2002, Dr. Fino pointed out that the Claimant's earlier x-rays show round opacities in the upper lung zones. A 1.25 to 1.75 centimeter round solid-appearing mass in the upper portion of the right lung and an increased density in the left upper lung were also apparent. (EX 12 at 36) Viewing this series of films and CT scans, Dr. Fino concluded that pneumoconiosis was not present: during that time, the rounded opacities remained unchanged, the right upper lobe mass lesion decreased in size, a lucency appeared in 1998 and disappeared by 2002, and the mass in the upper right lung stranded into the lateral lung or pleural surface. (EX 12 at 37-38) Dr. Fino concluded that these findings were more indicative of "a granulomatous process or . . . sarcoidosis," which are not coal mine dust related conditions. (EX 12 at 38-39)

Dr. Fino felt that the Claimant's CT scan, which showed a right upper lobe solid lesion with stranding into the pleura, was more consistent with granulomatous disease than pneumoconiosis. While he believed that the rounded opacities seen on Claimant's chest x-ray and CT scans could be consistent with either simple pneumoconiosis or chronic nodular granulomatous changes, he nevertheless felt that the Claimant does not have a disabling respiratory impairment. In his opinion, complicated pneumoconiosis was not a correct diagnosis.

Dr. Paul Wheeler

Dr. Paul Wheeler testified by deposition on April 11, 2005. (EX 11) He has been board-certified in radiology since 1969, and he is an associate professor of radiology. (EX 11 at 5) He is a NIOSH-certified B reader and has served on the American College of Radiology's task force for pneumoconiosis. (EX 11 at 7, 11)

Dr. Wheeler reviewed the following x-rays and CT scans: May 27, 1997 x-ray; March 2, 1998 x-ray; November 19, 1998 x-ray; June 29, 2000 x-ray; June 27, 2001 x-ray; March 14, 2002 x-ray; April 2, 2002 x-ray; April 15, 2002 x-ray and CT scan; July 23, 2002 x-ray; September 4, 2002 x-ray; September 17, 2002 x-ray and CT scan; (EX 11 at 28, 43, 57)

According to Dr. Wheeler, chest x-rays and CT scans that show pneumoconiosis share certain characteristics. First, they have small round symmetrical nodular patterns. (EX 11 at 28-29) Second, the opacities are "more likely" and "typically" located in the central portion of the mid and upper lung zones, but not the apex or periphery. (EX 11 at 28-29, 36-37) Third, the x-rays show no evidence of calcification. (EX 11 at 38)

Dr. Wheeler believed that Mr. Harrison's September 4, 2002 x-ray showed some Q nodules in the upper lobes, primarily in the apices in the upper lobe periphery, with 0/1 profusion. (EX 11 at 30, 34-35) While these nodules could be pneumoconiosis, Dr. Wheeler thought they were typical of granulomatous disease, because only about two diseases—tuberculosis and bolus emphysema—"sharpshoot" that part of the lung. (EX 11 at 30-31, 35)

With respect to Mr. Harrison's April 15, 2002 CT scan, Dr. Wheeler noted that the disease is primarily in the lower apices, with pleural involvement and an asymmetrical pattern. (EX 11 at 37) He relied on the calcium density readings, which at 49 to 94.3 were indeterminate, to conclude that inflammatory disease was a better diagnosis. Claimant's later x-ray, dated September 17, 2002, revealed density ratings of 102 and 141, which are in the calcium range, indicating the presence of a healed granulomatous infection, such as tuberculosis or histoplasmosis. (EX 11 at 39-40) Dr. Wheeler also pointed out the stability of the lesion over the years, indicating the presence of inflammatory disease, not pneumoconiosis. (EX 11 at 37-38) Upon examining the changes on Mr. Harrison's x-ray and CT scans, Dr. Wheeler concluded that the pattern went from nodular to a mass in the right apex, and from noncalcified to calcified in a matter of months. (EX 11 at 58) The fact that the x-ray shows calcium indicates that this is granulomatous disease. (EX 11 at 59)

Dr. Wheeler agreed that it is possible for a coal miner to have coal workers' pneumoconiosis that does not show up on x-ray. (EX 11 at 51) But in his experience, simple coal workers' pneumoconiosis does not progress without ongoing exposure. (EX 11 at 51) In his opinion, those persons who believe that pneumoconiosis can progress

without exposure have no actual autopsy or biopsy proof of what is progressing. (EX 11 at 51) He stated that there are four other diseases that produce round nodules which can progress without continued exposure. (EX 11 at 51-52)

DISCUSSION

Change in Condition of Entitlement

I find that, when compared to the evidence submitted in connection with the previous claim, the newly submitted evidence establishes by a preponderance of the evidence that Claimant is now totally disabled due to pneumoconiosis pursuant to 20 C.F.R. §718.304. Under 20 C.F.R. §718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from "complicated pneumoconiosis," although that term does not appear in the statute. A miner can establish complicated pneumoconiosis if he suffers from a chronic dust disease of the lung which:

> (a) When diagnosed by chest x-ray … yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C…; ***or***
>
> (b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; ***or***
>
> (c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: Provided, however, That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

20 C.F.R. §718.304 (emphasis added); s*ee Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250 (4th Cir. 2000). The Fourth Circuit has recently described the appropriate analysis under Section 21(c)(3) of the Act and the implementing regulations at 20 C.F.R. §718.304:[8]

> While 30 U.S.C. §921(c)(3) sets forth, in clauses (A), (B), and (C), three different ways to establish the existence of statutory complicated pneumoconiosis for purposes of invoking the irrebuttable presumption, these clauses are intended to describe a single, objective

[8] It is important to note that Section 21(c)(3) of the Act, 30 U.S.C. §921(c)(3), and Section 718.304 of the implementing regulations, 20 C.F.R. §718.304, are virtually identical in language, and the Fourth Circuit has treated them as interchangeable for purposes of invoking the irrebuttable presumption. *See Eastern*, 220 F.3d 250.

> condition. . . And, because prong (A) sets out an entirely objective scientific standard—i.e. an opacity on an x-ray greater than one centimeter—x-ray evidence provides the benchmark for determining what under prong (B) is a massive lesion and what under prong (C) is an equivalent diagnostic result reached by other means.
>
> Prongs (A), (B), and (C) are stated in the disjunctive; therefore a finding of statutory complicated pneumoconiosis may be based on evidence presented under a single prong. But the ALJ must in every case review the evidence under each prong of §921(c)(3) for which relevant evidence is presented to determine whether complicated pneumoconiosis is present. Evidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict. Yet, a single piece of relevant evidence can support an ALJ's finding that the irrebuttable presumption was successfully invoked if that piece of evidence outweighs conflicting evidence in the record. Thus, even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) or (C), then all of the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray. Of course, if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problems with the equipment used, or incompetence of the reader.

Eastern, 220 F.3d at 255-6 (internal quotations and citations omitted). Furthermore, the Fourth Circuit emphasized that the parties should not assume "that the statutory definition of 'complicated pneumoconiosis' must be congruent with a medical or pathological definition." *Id.* at 257. Instead, it is important to remember in the determination of complicated pneumoconiosis that the presumption under 20 C.F.R. §718.304 "is triggered by a congressionally defined condition." *Id.* In other words, invocation of the irrebuttable presumption does not require any additional clinical finding if prong (A), (B), or (C) is met.

The Court noted that the statute creating the irrebuttable presumption of causation does not refer to the condition as "complicated pneumoconiosis," or to a medical condition that doctors have independently called complicated pneumoconiosis. As the Court stated.

> [T]he presumption under § 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. . . . In short, the statute betrays no intent to incorporate a purely medical definition.

Eastern Associated Coal Corporation, 250 F.3d at 257.

Thus, if the Claimant meets the congressionally defined condition, that is, if he establishes that he has a condition that manifests itself on x-rays with opacities greater than one centimeter, he is entitled to the irrebuttable presumption of total disability due to pneumoconiosis, unless there is affirmative evidence under prong A, B, or C that persuasively establishes either that these opacities do not exist, or that they are the result of a disease process unrelated to his exposure to coal mine dust.

Here, the Claimant has presented three x-ray interpretations clearly satisfying the requirements of prong (A): the interpretations by Dr. Baker, Dr. Cappiello, and Dr. DePonte. However, there are other x-ray interpretations that do not note the presence of a category A opacity, as well as CT scan evidence. Thus, I must consider all of that evidence to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray. *Eastern Associated Coal*, 220 F.3d at 255-6.

Three highly qualified and experienced physicians – Dr. Baker, who is a B reader, and Dr. Cappiello and Dr. DePonte, who are B-Readers and Board Certified Radiologists – found category A opacities in Claimant's x-ray films, clearly meeting the requirements of prong (A). Thus, under *Eastern Associated Coal*, that x-ray evidence meeting prong (A) can lose force only if the other x-ray evidence, or the CT scan evidence, *affirmatively* shows that the opacities are not there or are not what they seem to be. 220 F.3d at 255-6.

I find that the Employer has not offered affirmative evidence sufficient to cause Dr. Baker's, Dr. DePonte's, or Dr. Capiello's interpretations to lose force. Instead, Employer has relied on x-ray and CT scan interpretations that acknowledge the presence of a large mass, but speculate that it is the result of a variety of conditions other than pneumoconiosis, without sufficient corroboration or evidentiary support.

Thus, Dr. Baker noted a Category A opacity on the Claimant's March 14, 2002 x-ray. Dr. Scott, who is dually qualified, noted a 2 cm. mass in the right apex, which he attributed to either granulomatous disease or cancer. Given his notation of a 2 cm. mass, I find that Dr. Scott's interpretation is not affirmative evidence that the opacity noted by Dr. Baker is not there. Nor is it affirmative evidence that this opacity is due to a disease

process other than pneumoconiosis: I find that Dr. Scott's interpretation is equivocal and speculative, especially in light of the fact that there is no evidence in the record to suggest that the Claimant has ever had or been exposed to any type of granulomatous disease. Moreover, there have been no findings or even suggestions of cancer in the interpretations of the x-rays and CT scans by the Claimant's treating physician, Dr. Verzosa.

Dr. Cappiello, who is dually qualified, found category A opacities on the Claimant's July 23, 2002 x-ray; however, Dr. Scatarige, who is also dually qualified, found this film to be negative for pneumoconiosis, with subtle nodular infiltrates in both apices, that "favored" tuberculosis or histoplasmosis.

Dr. Wheeler, who is dually qualified, reviewed an x-ray dated September 4, 2002, rating it as 0/1, with category O opacities. However, he noted a 2 to 3 cm. mass in the lower right apex, which he found to be compatible with granuloma, scar, or tumor. He acknowledged that a few small nodules "could be" pneumoconiosis.

Dr. Verzosa, who is the Claimant's treating physician, noted conglomerate nodules in his upper lobes, suggestive of pneumoconiosis, on his September 17, 2002 x-ray; he also noted a conglomerate larger mass in the right upper lobe. Dr. Fino, who is a B reader, interpreted this x-ray as negative for pneumoconiosis. In his narrative report, Dr. Fino discussed this x-ray, as well as x-rays and CT scans dating back to 1998. He noted that they all showed a moderate amount of rounded opacities in both upper lung zones, which did not change over time, a 1-2 cm. solid appearing mass that decreased by about a quarter of a centimeter, and an area of increased density in the upper left lung that did not change over time. The CT scans confirmed the presence of the rounded opacities, but showed that there was no solid mass in the upper left lung; there was a ½ to 2 cm. solid appearing mass in the central right upper lobe.

Clearly, Dr. Fino's report is not affirmative evidence that the large opacity identified by Dr. Baker, Dr. Cappiello, and Dr. DePonte is not there, as he acknowledged the presence of the mass in the right upper lobe. Dr. Fino also acknowledged that the rounded opacities on the Claimant's x-rays and CT scans could be pneumoconiosis. But he was "certain" that the "diagnosis" of complicated pneumoconiosis was incorrect. Noting the sensitivity of CT scans, Dr. Fino argued that the right upper lobe lesion was not consistent with complicated pneumoconiosis, but was "much more consistent" with granulomatous disease. He did not offer any support for this statement.

Dr. Fino also based his conclusion on his expectation that with complicated pneumoconiosis, pulmonary function studies would show a significant respiratory impairment, which was not present here. Of course, this ignores the statutory concept that the condition referred to in § 304 is a congressionally defined condition, not a strictly medical condition. Indeed, in order to be entitled to the statutory presumption under § 304, a claimant need not demonstrate that he has any pulmonary impairment at all.

I find Dr. Fino's conclusions to be speculative and equivocal, as well as conclusory and unsupported; in short, they are not persuasive affirmative evidence that the large opacities identified by Dr. Baker, Dr. Cappiello, and Dr. DePonte are due to a process other than pneumoconiosis.

Again, on the Claimant's March 31, 2003 x-ray, Dr. Scatarige, who is dually qualified, found pneumoconiosis, as well as a 2.5 cm. infiltrate or mass in both lung apices, with a background of small nodules. As he noted the presence of the large mass, his interpretation is certainly not affirmative evidence that the opacities noted by Dr. Baker, Dr. Cappiello, and Dr. DePonte are not there. His conclusion that this mass "favored" tuberculosis of "uncertain" etiology, rather than pneumoconiosis, is speculative and equivocal, and does not rise to the level of affirmative evidence sufficient to establish that the large opacities identified by Dr. Baker, Dr. Cappiello, and Dr. DePonte are due to a process other than pneumoconiosis.

Finally, Dr. DePonte, who is dually qualified, noted pneumoconiosis, as well as category A opacities in the mid to upper lung zones on the Claimant's June, 2004 x-ray. Dr. Wheeler rated this x-ray as 0/1, or negative for pneumoconiosis. But he found a 3 cm. mass in the lower posterior right apex. Again, as he acknowledged the presence of the large mass, I find that Dr. Wheeler's interpretation is not affirmative evidence that the opacities noted by Dr. Baker, Dr. Cappiello, and Dr. DePonte are not there. Curiously, Dr. Wheeler stated that this mass was not a "large opacity." Clearly, he was able to see this mass on the x-ray. If he meant that this mass did not qualify as a "large opacity" representing complicated pneumoconiosis, he did not explain the basis for such a conclusion. Nor was he willing to ascribe an etiology to this mass, other than to speculate that it was due to tuberculosis, or possibly histoplasmosis or cancer.

But although they acknowledged the presence of the large mass, Dr. Scott, Dr. Wheeler, and Dr. Scatarige did not address the issue of whether it met the statutory requirements under §718.304. Certainly, they did not provide an explanation that could be considered affirmative evidence that would cause the evidence that meets the standard under prong (A) to lose force. Instead, Dr. Scott simply stated that the mass he saw was "either/or" granulomatous disease or cancer. Dr. Scatarige thought that the mass "favored" tuberculosis of "uncertain" etiology. Finally, Dr. Wheeler provided yet a different interpretation: he concluded that Claimant's September 4, 2002 x-ray "could" show a few small nodules of pneumoconiosis, but he felt that the mass was consistent with granulomatous disease, *or* a scar, *or* a tumor.[9] But while these physicians are willing to exclude pneumoconiosis as a cause for the mass, they are not willing to make an affirmative diagnosis of the etiology of this mass. In short, I find no reason to attribute any affirmative weight to medical interpretations that acknowledge the objective findings in the x-ray evidence—i.e. the presence of a large mass—but speculate without basis that that same objective evidence must be due to something else.

[9] It is important to note that nothing in the record indicates that Claimant was ever diagnosed with, treated for, hospitalized for, complained of, or displayed symptoms of tuberculosis.

There is also evidence that falls under Prong C, in the form of numerous CT scan interpretations. All of the physicians who reviewed the CT scans noted the presence of the large mass in the Claimant's lungs. None of these physicians addressed the issue of whether these large masses would appear on x-ray as an opacity of at least 1 centimeter in diameter. On the other hand, given the consistent findings of large masses, I find that these CT interpretations do not constitute affirmative evidence that the large opacities noted by Dr. Baker, Dr. Cappiello, and Dr. DePonte are not there.

Without explanation or support, Dr. Fino concluded that the solid lesion in the Claimant's right upper lobe was "more consistent" with granulomatous disease than pneumoconiosis. And while acknowledging that the rounded opacities could be consistent with simple pneumoconiosis (or granulomatous changes), he insisted that complicated pneumoconiosis was not a correct "diagnosis," because the Claimant does not have a respiratory impairment. But again, Dr. Fino appears to be relying on the medical definition of complicated pneumoconiosis, when the statute and regulations incorporate a congressionally defined condition, which does not require the existence of *any* impairment.

Dr. Wheeler relied on "indeterminate" calcium density readings to conclude that inflammatory disease was a "better" diagnosis, and later density readings in the "calcium range," which he felt indicated a healed granulomatous infection such as tuberculosis or histoplasmosis.[10] Although he stated that the mass went from noncalcified to calcified, and from nodular to a mass in a matter of months, he relied on the fact that the lesion was stable over the years for his conclusion that it was inflammatory disease, not pneumoconiosis. I find his opinions to be confusing, and without adequate support; equivocal; and not persuasive affirmative evidence that the opacities seen on x-ray are due to a process other than pneumoconiosis

I also find that the reliability of Dr. Wheeler's opinions is diminished by his insistence that simple pneumoconiosis does not progress without ongoing exposure to coal dust. This is contrary to the statutory concept that pneumoconiosis is a progressive disease. Nor does Dr. Wheeler offer any support for this statement, or identify the four "other" diseases that produce round nodules, and progress without continued exposure.

Finally, I find that the reports by Dr. McSharry and Dr. Foster do not constitute affirmative evidence sufficient to rebut the presumption raised by the Category A findings on x-ray. Certainly the treatment notes and reports from Dr. Foster do nothing to rebut that presumption, as he repeatedly noted findings consistent with pneumoconiosis, and bilateral upper lobe opacities consistent with conglomerate shadows of pneumoconiosis. Indeed, in his most recent report in April 2003, Dr. Foster concluded that the Claimant had pneumoconiosis with progressive massive fibrosis.

Nor do I find Dr. McSharry's report affirmative evidence that rebuts the regulatory presumption. Dr. McSharry examined the Claimant on September 4, 2002,

[10] I note that in his exhaustive report on the March 31, 2003 CT scan, Dr. Verzosa noted that there was no calcification.

and reviewed selected medical records. Curiously, although he was provided with the interpretations of the Claimant's March 14, 2002 x-ray by Dr. Scott and Dr. Wheeler, Dr. McSharry was not provided with Dr. Baker's interpretation of this film, in which he noted the presence of Category A opacities.[11]

Dr. McSharry also obtained an x-ray during his examination of the Claimant, which apparently was interpreted by Dr. Wheeler as showing "equivocal" changes of coal workers' pneumoconiosis (0/1, q, q), and a mass 2 to 3 centimeters in size. Dr. McSharry concluded that there was adequate objective evidence to diagnose coal workers' pneumoconiosis, based on the Claimant's prolonged history of exposure to coal dust, and radiographic changes that Dr. McSharry felt were suggestive of pneumoconiosis. In this regard, he disagreed with Dr. Wheeler and Dr. Scott.

Dr. McSharry was not able to identify with certainty a 1 centimeter or greater mass on the Claimant's September 4, 2002 x-ray, and thus felt that the Claimant had simple, but not complex coal workers' pneumoconiosis. Nor did he see evidence of a lesion of progressive massive fibrosis. He agreed that a CT scan would be helpful, but stated that if the mass in the right upper lung zone were confirmed on CT scan, he "would be inclined to agree that the requirements for a diagnosis of complicated coal workers pneumoconiosis had been met, assuming the nodules in the upper lung zones appear to be pneumoconiosis (as I believe they are)."

Clearly, Dr. McSharry did not have Dr. Baker's x-ray interpretation, which was certainly available to the Employer at the time of Dr. McSharry's examination, nor did he have the opportunity to review later x-ray films or interpretation, or more importantly, the results of the two CT scans, in particular, the identification of the mass in the right upper lobe by Dr. Verzosa and Dr. Wheeler. If anything, Dr. McSharry's report strongly supports a conclusion that the Claimant has complicated pneumoconiosis, as that term is defined in the Act.

In sum, Employer has offered a number of x-ray interpretations and medical reports that, when considered together, do not affirmatively establish that the large opacity is not there or is due to another disease process. Instead, Employer's evidence as a whole merely suggests the possibility that the large mass acknowledged by virtually every physician of record is probably something other than pneumoconiosis. The fact remains, there is no consistent, corroborated, or affirmative evidence that the large opacities identified by Dr. Baker, Dr. Cappiello, and Dr. DePonte are not there, or are due to an intervening pathology. The only thing Dr. Wheeler, Dr. Scott, Dr. Scatarige, and Dr. Fino can agree on is that the large opacity is *probably* due to something else, and they

[11] Dr. Wheeler's interpretation of the March 14, 2002 x-ray is not part of the record. Nor is Dr. McSharry's interpretation of the Claimant's September 4, 2002 x-ray, as the Employer chose to submit Dr. Wheeler's interpretation. Thus, I have not considered Dr. McSharry's interpretation in making my determination as to whether the Claimant has established his entitlement to the regulatory presumption of complicated pneumoconiosis. It is clear that Dr. McSharry's conclusions are heavily reliant on Dr. Scott's interpretation, as well as his own x-ray interpretation. If I were to separate out those portions of Dr. McSharry's report that do not rely on evidence not in the record, there would be nothing left of any use. In either case, whether I consider the report *in toto* or not, it is not helpful to the Employer's position.

offer divergent views on what those possibilities could be. I find that their opinions are not affirmative evidence under *Eastern Associated Coal*.

Therefore, inasmuch as the other evidence does not affirmatively show that the opacities are not there or are not what they seem to be, the Claimant's x-ray evidence under prong (A) does not lose force. Consequently, Section 21(c)(3) and the implementing regulations at 20 C.F.R. §718.304 compel me to invoke the irrebuttable presumption that the Claimant is totally disabled due to pneumoconiosis.

After careful examination of the evidentiary record, it is clear that the newly submitted x-ray evidence differs qualitatively from the evidence submitted with the previously denied claim. The District Director determined that the Claimant had not established that he was totally disabled due to pneumoconiosis, because the values obtained from pulmonary function and arterial blood gas testing did not meet disability standards under the regulations. The District Director made no determination of whether the evidence in Claimant's previous claim established the existence of either simple or complicated pneumoconiosis. In the previous claim, Dr. Townsend and Dr. Sargent submitted x-ray interpretations finding simple pneumoconiosis, but there were no findings of complicated pneumoconiosis.

In the present case, three different physicians have made unequivocal x-ray findings of category A opacities, supporting a finding of complicated pneumoconiosis. Additionally, as discussed above, while they do not acknowledge them as complicated pneumoconiosis, virtually every other physician who has reviewed the x-rays agrees on the presence of the large mass. Thus, the newly submitted evidence meets the criteria under the Act, establishing by a preponderance of the evidence that the Claimant has complicated pneumoconiosis.

Additionally, as noted above, the District Director's determination that Claimant did not establish total disability due to pneumoconiosis was based solely on the pulmonary function and arterial blood gas study results. Now, Claimant has produced evidence of a completely different nature—that is, x-ray evidence under §718.304—that establishes total disability due to pneumoconiosis. Based on the foregoing, it is clear that the Claimant's condition has worsened since 1997. Thus, I find that the preponderance of the evidence demonstrates that the Claimant has established a material change in conditions pursuant to 20 C.F.R. §725.309—i.e., Claimant has demonstrated that a change has occurred in the applicable condition of entitlement upon which the denial of his prior claim was based.

The inquiry, however, does not end there. As noted above, invocation of the irrebuttable presumption also creates a presumption that the miner is or was suffering from pneumoconiosis. 20 C.F.R. §718.202(a)(3). There is evidence in the record, which has been discussed at length above, that provides some rebuttal to that presumption, and I must briefly address it here. For the following reasons, however, I find that the presumption that Claimant suffers from pneumoconiosis pursuant to §718.202(a)(3) has not been successfully rebutted. Dr. Wheeler, Dr. Scott, and Dr. Fino found insufficient

evidence to diagnose even simple coal workers' pneumoconiosis, although Dr. Wheeler acknowledged that a "few" of the small nodules on the x-rays "could be" pneumoconiosis. Although he read the Claimant's July 23, 2002 x-ray as negative for pneumoconiosis, Dr. Scatarige interpreted his March 31, 2003 as 1/0. Dr. Baker, Dr. Cappiello, Dr. Verzosa, and Dr. DePonte concluded there is x-ray evidence consistent with pneumoconiosis. In short, the preponderance of the persuasive newly submitted evidence establishes that the Claimant has simple pneumoconiosis under the Act. Consequently, I find that the evidence of record does not rebut the presumption under §718.202(a)(3) that Claimant suffers from pneumoconiosis.[12]

Based on the foregoing, I find that the Claimant has met the threshold determination by demonstrating a change in the applicable condition of entitlement under 20 C.F.R. §718.309. Accordingly, I must now examine the record to determine whether the Claimant is entitled to benefits. I have reviewed all of the Claimant's medical records from his previous claims, and I note that there is no evidence of complicated pneumoconiosis. However, pneumoconiosis is a progressive disease, and I find that the absence of x-ray findings of large opacities in the previous medical records does not diminish the probative force of the more recent x-ray findings.

Thus, after reviewing all of the medical evidence of record, I find that the Claimant has established that he suffers from pneumoconiosis that arose out of his coal mine employment, and that he is totally disabled due to his pneumoconiosis. The Claimant is therefore entitled to benefits under the Act.

Because I find that Claimant is entitled to benefits under the Act, I must determine the onset date—i.e., the date on which benefits should commence. If a claimant establishes that he has complicated pneumoconiosis under 30 U.S.C. §921(c)(3), the onset date is the month during which complicated pneumoconiosis was first diagnosed. *Truitt v. North American Coal Corp.*, 2 B.L.R. 1-199, 1-203 to 1-204 (1979). If the evidence does not reflect when a claimant's condition became complicated pneumoconiosis, the onset date for payment of benefits is the month during which the claim was filed. *Williams v. Director, OWCP*, 13 B.L.R. 1-28 (1989). The Claimant bears the burden of proof in establishing the date of onset of total disability. *See, e.g., Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). The administrative law judge must consider all relevant evidence of record and assess the credibility of that evidence, in her determination of the onset date. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181 (1989).

Here, the record is clear that the earliest date of the newly submitted medical evidence diagnosing Clamant with complicated pneumoconiosis is March 14, 2002. As discussed above, I have found that evidence to be probative and reliable, and I based my determination that Claimant suffers from complicated pneumoconiosis, at least in part, upon that evidence. Therefore, inasmuch as the x-ray evidence of March 14, 2002 establishes the existence of opacities that satisfy prong (A) of Section 21(c)(3) of the Act,

[12] As the Claimant has over 22 years of coal mine employment, he is also entitled to the regulatory presumption that his pneumoconiosis arose from his coal mine employment, a presumption that has not been rebutted.

I find that the Claimant was diagnosed with complicated pneumoconiosis as of that date. Accordingly, the onset date upon which benefits are to commence is March 14, 2002.

CONCLUSION

I find that the Claimant has established by a preponderance of the medical evidence that he suffers from complicated pneumoconiosis and is entitled to the irrebuttable presumption under 20 C.F.R. §718.304. Accordingly, I also find that the Claimant established a material change in condition under §725.309—i.e., the newly submitted x-ray evidence establishes that Claimant now has complicated pneumoconiosis. I further find that Claimant is entitled to the presumptions set forth in 20 C.F.R. §§718.202(a)(3) and 718.302, and Employer has not rebutted those presumptions. Therefore, Claimant is entitled to benefits under the Act as of March 14, 2002.

ORDER

It is ordered that the claim of Ronald D. Harrison for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the Employer, Sunset Land & Coal Company, shall pay to the Claimant all benefits to which he is entitled under the Act beginning in March, 2002.

SO ORDERED.

A

LINDA S. CHAPMAN
Administrative Law Judge

ATTORNEY'S FEES

An application by Claimant's attorney for approval of a fee has not been received. Thirty days is hereby allowed to Claimant's counsel for submission of such an application. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. The parties have ten days following receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).